



POLICY & PROCEDURE (P&P) APPROVAL REQUEST FORM

I. P&P INFORMATION

Assigned Policy Name: Beneficiary Problem Resolution

Assigned Policy Number: BHSD 12000

Policy Area(s): Mark All That Apply

- | | |
|---|--|
| <input type="checkbox"/> Plan Administration and Organization | <input type="checkbox"/> Provider Network |
| <input type="checkbox"/> Scope of Services | <input type="checkbox"/> Documentation Requirements |
| <input type="checkbox"/> Financial Reporting Requirements | <input type="checkbox"/> Coordination and Continuity of Care |
| <input type="checkbox"/> Management Information Systems | <input type="checkbox"/> Beneficiary Rights |
| <input type="checkbox"/> Quality Improvement System | <input checked="" type="checkbox"/> Beneficiary Problem Resolution |
| <input type="checkbox"/> Utilization Management Program | <input type="checkbox"/> Program Integrity |
| <input type="checkbox"/> Access and Availability of Services | <input type="checkbox"/> Reporting Requirements |

Submitted by: victor Ibabao Date: 5/13/2019

Policy developed by: Tianna Nelson and Domingo Acevedo

Attach P&P Document For Review In this Section [Include Paperclip Icon Here]



II. APPROVAL

Section A: HHS Compliance and County Counsel

HHS Compliance: DocuSigned by: Victoria Phan Date: 5/13/2019

County Counsel: 3527B4B4F12742C... DocuSigned by: Lorraine Van Kirk Date: 5/14/2019

Section B: BHSD Executive Director

BHSD Executive Director: DocuSigned by: Toni Tullys Date: 5/16/2019

Note - A copy of the Approved P&P Form will be emailed to: BHSD Compliance Unit



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<input checked="" type="checkbox"/>	BHSD County Staff
<input checked="" type="checkbox"/>	Contract Providers
<input checked="" type="checkbox"/>	Specialty Mental Health
<input checked="" type="checkbox"/>	Specialty Substance Use Treatment Services

**Title: Beneficiary Problem Resolution Process
with Revised NOABD Templates**

Approved/Issue Date: 4/11/2018	Behavioral Health Services Director: Toni Tullys	
Last Review/Revision Date: 5/2/2019	Next Review Date:	Inactive Date:

REFERENCE:

- 42 CFR §§ 431.211-214 Notice.
- 42 C.F.R. § 431.220 When a Hearing Is Required.
- 42 CFR § 431.244(f) Expedited Appeals.
- 42 CFR § 438 Managed Care.
- 42 CFR § 438, Subpart F Grievance and Appeal System.
- 42 CFR § 438.10 Information Requirements.
- 42 CFR § 438.228 Grievance and Appeals Systems.
- 42 CFR § 438.400 (b) Statutory Basis, Definitions, and Applicability.
- 42 CFR §§ 438.402 (b) - (c) General Requirements.
- 42 CFR §§ 438.404 (b)-(c) Timely and Adequate Notice of Adverse Benefit Determination.
- 42 CFR §§ 438.406 (a)-(b) Handling of Grievances and Appeals.
- 42 CFR §§ 438.408(b)-(f) Resolution and notification: Grievances and appeals.
- 42 CFR § 438.410 (c) Expedited resolution of appeals.
- 42 CFR § 438.414
- 42 CFR § 438.416 (b) Recordkeeping requirements.
- 42 CFR § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending.
- 42 CFR § 438.424(a) Effectuation of reversed appeal resolutions.
- 45 CFR § 92.8 Notice requirement.
- 81 FR 27497 Medicaid and Children's Health Insurance Program (Chip) Programs; Medicaid Managed Care, Chip Delivered In Managed Care, and Revisions Related to Third Party Liability.
- 81 FR § 31375 Nondiscrimination in Health Programs and Activities
- 9 CCR § 1810.200 Action.
- 9 CCR § 1810.230.5 Notice of Action.
- 9 CCR § 1810.216.2 Expedited Appeal.
- 9 CCR § 1810.216.4 Expedited Fair Hearing.
- 9 CCR § 1810.440 MHP Quality Management Programs.



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- 9 CCR §1820.100 Definitions.
- 9 CCR §1830.100 General Provisions.
- 9 CCR §1830.205 Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.
- 9 CCR §1830.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.
- 9 CCR §§1850.205-1850.215 Beneficiary Problem Resolution Processes.
- 22 CCR § 51014.1-2 Medical Assistance Pending Fair Hearing Decision.
- 22 CCR § 50179. Notice of Action Medi-Cal-Only Determinations or Redeterminations.
- 22 CCR § 53858 (e) Member Grievance Procedures.
- 28 CCR § 1300.67.04 Language Assistance Programs.
- 28 CCR §1300.68(a) Grievance System.
- HSC §1367.01 Health Care Service Plans.
- HSC §1368 Grievance System
- DHCS All Plan Letter 17-006
- DHCS Information Notice: 18-010
- Beneficiary Request for Second Opinion BHSD# 11200.1
- Beneficiary Request for Second Opinion SUTS BHSD# 11200.2

POLICY:

Beneficiaries that receive BHSD services may file a grievance or appeal and have their concerns addressed through a clearly defined problem resolution process if they are not satisfied with their behavioral health services or steps taken by BHSD. Behavioral Health Services Department for the County of Santa Clara has a three-tiered resolution process:

1. The Provider level, beneficiaries or beneficiary representatives are encouraged to resolve concerns at the program level where services are received,
2. The BHSD Plan level, beneficiary may submit a formal grievance and/or appeal to the MCP.
 - a. An internal hearing (for uninsured beneficiaries only) is available if beneficiaries are not satisfied with the result of their grievance and appeal.
3. The State Fair Hearings Division (for Medi-Cal beneficiary's only).
 - a. Beneficiaries and beneficiary representatives are required to exhaust the BHSD problem resolution process prior to filing for a State Fair Hearing.
4. Internal Fair Hearing (for uninsured beneficiaries only)
 - a. Beneficiaries and beneficiary representatives are required to exhaust the BHSD



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problem resolution process prior to filing for an Internal Fair Hearing.

BHSD service beneficiaries have rights specific to:

1. File a grievance/appeal orally or in writing in the language of their choice.
2. Authorize another person, a representative, to act on their behalf.
3. To obtain a second opinion (refer to Beneficiary Request for Second Opinion BHSD# and Beneficiary Request for Second Opinion BHSD# 11200.2)
 - a) Beneficiaries can delay their grievance/appeal pending the outcome of the second opinion or proceed with both processes at the same time.
4. At any stage of the problem resolution process, the beneficiary may access:
 - a) The DHCS MMCO "Medi-Cal Managed Care Office of Ombudsman" as a neutral advocate to answer questions. These services are available M – F 8a.m. to 5 p.m. PST at 1-888-452-8609.
 - b) For mental health service questions, additional support may also be obtained from one or more beneficiary advocates, including Mental Health Advocacy Project at 408-294-9730 or 800-248-6427 x420, or Disability Rights California for legal assistance at 800-776-5746.
 - c) For substance use services questions, additional support may be obtained at the SUTS Benefits Line (408)-792-5666.
5. Beneficiaries and their representative (with proper consent), before and during the appeals process, may examine the beneficiary's clinical record and any other documents and records to be considered during the appeal process. This information will be provided free of charge and sufficiently in advance of the resolution timeframe.
6. Beneficiaries will be given a reasonable opportunity to present evidence in person as well as in writing.
7. All grievances, appeals, and expedited appeals will be resolved within the established timeframes and any required notice of an extension is given. See Timeliness Standards Section.
8. Will not be subject to discrimination or any other penalty or punitive action for filing a grievance, appeal, or expedited appeal.
9. Confidentiality will be maintained throughout the beneficiary resolution process.
10. Beneficiaries may request BHSD assistance in preparing a written appeal.
11. In the event BHSD does not receive a written, signed Appeal from the beneficiary, BHSD will neither dismiss nor delay resolution of the Appeal.
12. Beneficiaries or their representatives have the right to request a State Fair Hearing if BHSD fails to send a resolution notice in response to an Appeal within the required



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timeframe.

13. BHSD’s beneficiary problem resolution process will not replace or conflict with the duties of beneficiary’s rights advocates.

BHSD providers contracted to provide services must inform beneficiaries when those services will be reduced, limited, denied or modified. The mechanism to notify beneficiaries is called a Notice of Adverse Benefit Determination, NOABD. This policy describes the situations that warrant a NOABD and the process through which a NOABD is issued to ensure accordance with State regulations, so that beneficiaries are able to exercise their rights in response to a NOABD

BHSD delegates submission of certain NOABD’s to providers as follows:

When the Provider:

1. Is unable to meet timely access standards
2. Must modify a service requested by a beneficiary.
3. Must terminate a beneficiary service;

When the Beneficiary:

4. Does not meet medical necessity criteria
5. Requests a service that is not covered
6. Asks for payment to be approved for a service which was received that BHSD does not cover.
7. Disputes financial liability such as cost-sharing or co-insurance.

DEFINITIONS:

Appeal. A review by BHSD or Contract Agency of an adverse benefit determination.

Beneficiary. A Medi-Cal recipient who is currently receiving services from BHSD or a BHSD contracted provider.

Grievance. An expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary’s rights regardless of whether remedial action



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is requested. Grievance includes a beneficiary’s right to dispute an extension of time proposed by BHSD to make an authorization decision. (42 C.F.R. § 438.400)

Provider. A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.

PROCEDURE	
Processes	Mandated Requirements
GRIEVANCES	<ol style="list-style-type: none"> 1. Timeframes for filing <ol style="list-style-type: none"> a. At any time 2. Method of filing <ol style="list-style-type: none"> a. Orally or in writing 3. Who may file <ol style="list-style-type: none"> a. Beneficiary b. Authorized representative c. Provider on behalf of the beneficiary 4. Standard Grievances <ol style="list-style-type: none"> a. Acknowledgement <ol style="list-style-type: none"> i. In writing ii. Postmarked within 5 calendar days of receipt of grievance b. Resolution <ol style="list-style-type: none"> i. Within an established timeframe of 90 calendar days for resolution of grievances except: <ol style="list-style-type: none"> 1. Grievances related to disputes of the MCP’s decision to extend the timeframe for making an



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	<p>authorization decision will not exceed 30 calendar days.</p> <ul style="list-style-type: none"> ii. Complete and send the Notice of Grievance Resolution (NGR) template to notify beneficiaries of the results of the grievance resolution. <ul style="list-style-type: none"> 1. NGR will contain a clear and concise explanation of the decision. <p>c. Extensions</p> <ul style="list-style-type: none"> i. Can be extended an additional 14 calendar days: <ul style="list-style-type: none"> 1. Beneficiary requests 2. Plan shows a need for additional information and how the delay is in the beneficiary's interest. ii. Provide beneficiary with the applicable NOABD, include status of grievance, estimated date of resolution, which will not exceed 14 additional calendar days. iii. If BHSD extends the timeframe for any grievances that wasn't requested by the beneficiary, BHSD makes reasonable efforts to give the beneficiary prompt oral notice of the delay and give the beneficiary written notice of the extension and the reasons for the extension within 2 calendar days of the decision to extend the timeframe. <ul style="list-style-type: none"> 1. The written notice of extension shall inform the beneficiary of the right to file a grievance if beneficiary disagrees with the BHSD's decision <p>d. Grievance Process Exemptions</p> <ul style="list-style-type: none"> i. Grievances received over the telephone or in person that are resolved to the beneficiaries satisfaction by the close of the next business day following receipt are
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	<p>exempt from the written acknowledgement and disposition letters.</p> <ul style="list-style-type: none"> ii. Grievances received via mail are not exempt from requirement to send acknowledgement and disposition letters. iii. Complaints pertaining to a Notice of Adverse Benefit determination is not considered a grievance and the exemption does not apply. <p>e. Grievance Logs</p> <ul style="list-style-type: none"> i. Must maintain a log of all grievances, including the date of receipt of the grievance, the name of the beneficiary, nature of the grievances, the resolutions and the representative's name who received and resolved the grievances. This includes exempt grievances. ii. Must transmit de-identified information that describe issues identified as the result of the grievance, appeal or expedited appeals processes to the BHSD's administration and/or Quality Improvement Committee for quality improvement purposes. <p>2.</p>
<p>Notice of Adverse Benefit Determinations</p>	<p>1. Written Notice of Adverse Benefit Determination Requirements must explain:</p> <ul style="list-style-type: none"> a. The adverse benefit determination that has been or will be made. b. A clear and concise explanation of the reason(s) for the decision. <ul style="list-style-type: none"> i. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision and the right to a second opinion. ii. Will explicitly state why the beneficiary's condition does not meet specialty mental health services and/or DMC-ODS medical necessity criteria.



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	<ul style="list-style-type: none"> c. A description of the criteria used. This includes medical necessity criteria and any processes, strategies or evidentiary standards used in making such determinations. d. The beneficiary’s right to be provided on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary’s adverse benefit determination. e. NOABD must include the name and the direct telephone number or extension of the decision-maker. f. Decisions may be communicated to providers initially by telephone or facsimile and then in writing, except decisions rendered retrospectively. <p>2. Timing of Notice</p> <ul style="list-style-type: none"> a. For termination, suspension or reduction of a previously authorized specialty mental health and/or DMC-ODS service, at least 10 days before the date of the action. b. For denial of payment, at the time of any action denying a provider’s claim. c. For decisions resulting in the denial, delay or modification of all or part of the requested specialty mental health and/or DMC-ODS services, within two business days of the decision. <p>3. Advance Notice Exemptions</p> <ul style="list-style-type: none"> a. The Plan is exempt from sending an advance notice when: <ul style="list-style-type: none"> i. The provider has factual information confirming the death of a beneficiary. ii. The provider receives a clear written statement signed by the beneficiary that: <ul style="list-style-type: none"> 1. They no longer want services 2. Gives information that requires termination or reduction of services and indicates they understand this
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	<p>must be the result of supplying the information.</p> <ul style="list-style-type: none"> iii. Beneficiary has been admitted to an institution where they are ineligible under the plan for further services. iv. Beneficiary whereabouts are unknown and/or post office returns agency mail directed to the beneficiary indicating no forwarding address v. Plan establishes that the beneficiary has been accepted for Medicaid services by another jurisdiction, state, territory or commonwealth. vi. . A change in the level of care is prescribed by the beneficiary’s physician. vii. The notice involves an adverse determination made with regard to preadmission screening requirements. <p>b. Advance Notice Exceptions date of action will occur in less than 10 days.</p>
Written NOABD Templates	<ol style="list-style-type: none"> 1. Must use DHCS uniform notice templates or the electronic equivalent of these templates generated from the provider electronic health record system. 2. Notice templates include both the NOABD and “Your Rights” documents. 3. DENIAL template is used when the MCP denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. For DMC-ODS pilot counties, also use this template for denied residential service requests. 4. PAYMENT DENIAL Template for is used when the MCP denies, in whole or in part, for any reason, a provider’s request for payment for a service that has already been delivered to a beneficiary. 5. DELIVERY SYSTEM template is used when the MCP has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder



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	<p>services through the plan. The beneficiary will be referred to the managed health care plan, or other appropriate system, for mental health, substance use disorder, or other services.</p> <p>6. MODIFICATION template is used when the Plan modifies or limits a provider’s request for a service including reductions in frequency and/or duration of services and approval of alternative treatments and services.</p> <p>7. TERMINATION template is used when the plan terminates, reduces or suspends a previously authorized service.</p> <p>8. TIMELY ACCESS template is used when there is a delay processing a provider’s and/or beneficiary’s request for authorization of specialty mental health services or substance use disorder residential services. When the plan extends the timeframe to make an authorization decision, it is a delay in processing a provider’s and/or beneficiary’s request. This includes extensions granted at the request of the beneficiary or provider and/or those granted when there is a need for additional information from the beneficiary or provider when the extension is in the beneficiary interest.</p> <p>9. TIMELY ACCESS template is used when there is a delay in providing the beneficiary with timely services as required by timely access standards applicable to the delayed service.</p> <p>10. FINANCIAL LIABILITY template is used when the plan denies a beneficiary’s request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.</p>
<p>NOABD “Your Rights” Attachment</p>	<p>1. Provides beneficiaries with information related to the NOABD:</p> <ul style="list-style-type: none"> a. The beneficiary or provider right to request an internal appeal with the Plan within 60 calendar days from the date on the NOABD. b. The beneficiary right to request a State hearing only after filing an appeal with the Plan and receiving a Notice that Adverse Benefit Determination has been upheld. c. The beneficiary right to request a State hearing if the Plan fails to send a resolution notice in response to the appeal within the required timeframe.



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	<ul style="list-style-type: none"> d. Procedures for exercising the beneficiary’s rights to request an appeal. e. Circumstances under which an expedited review is available and how to request it. f. The beneficiaries’ right to have benefits continue pending resolution of the appeal and how to request continuation of benefits. <ol style="list-style-type: none"> 2. Utilize the Your Rights attachment template or attachments generated from the provider electronic health record system. 3. Will not alter or change template without prior review and approval from DHCS with the exception of insertion of information specific to beneficiaries’ as required.
<p>APPEALS</p>	<ol style="list-style-type: none"> 1. Timeframes for filing <ul style="list-style-type: none"> a. Beneficiaries must file an appeal within 60 calendar days from the date on the NOABD. 2. Who can file <ul style="list-style-type: none"> a. Beneficiary b. Authorized representative c. Provider on behalf of the beneficiary with a written authorization from the beneficiary 3. Method of filing <ul style="list-style-type: none"> a. Orally b. In writing c. Appeals filed by provider on behalf of beneficiary require written beneficiary consent. d. Oral requests for standards appeals shall be followed by a written appeal signed by the beneficiary and confirmation of receipt of appeal. e. BHSD and BHSD providers shall assist beneficiary in completing forms and taking other procedural steps to file an appeal including preparing a written appeal, notifying beneficiary of the location of the form on the BHSD website or providing the form to the beneficiary on request. f. BHSD and providers will advise and assist the beneficiary in requesting continuation of benefits during an appeal of an adverse benefit determination.



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	<p>g. In the event that BHSD does not receive a written, signed appeal from the beneficiary, BHSD will not dismiss or delay resolution of the appeal.</p> <p>4. Authorized Representatives</p> <p>a. With written consent from the beneficiary, a provider or authorized representative may file a grievance, request an appeal or request a State hearing on behalf of a beneficiary.</p> <p>b. Only the beneficiary can request continuation of benefits.</p> <p>5. Standard Resolution of Appeals</p> <p>a. Acknowledgement</p> <p>i. BHSD will provide written acknowledgement of receipt of the appeal.</p> <p>ii. Acknowledgement letter will include:</p> <ol style="list-style-type: none"> 1. Date of receipt 2. Name, telephone number and address of the BHSD representative who the beneficiary may contact about the appeal. <p>iii. Must be postmarked within five calendar days of receipt of the appeal.</p> <p>b. Standard Resolution Timeframe</p> <p>i. Must be resolved within 30 days of receipt.</p> <p>c. Extension Timeframes</p> <p>i. BHSD may extend timeframes for appeals by up to 14 calendar days if either of the two conditions apply:</p> <p>ii. The beneficiary requests an extension.</p> <p>iii. BHSD demonstrates to the satisfaction of DHCS, on request, that there is a need for additional information and how the delay is in the beneficiary's best interest.</p> <ol style="list-style-type: none"> 1. BHSD must provide written notice of the reason for a delay not requested by the beneficiary.
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	<ol style="list-style-type: none"> 2. BHSD will make reasonable efforts to provide the beneficiary with prompt oral notice of the extension. 3. BHSD will provide written notice of the extension within two calendar days of making the decision to extend the timeframe and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension. 4. BHSD will resolve the appeal as expeditiously as the beneficiary’s health condition requires and in no event extend the resolution beyond the 14 calendar day extension. 5. In the event that BHSD fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the BHSD appeal process and may initiate a State hearing.
<p>EXPEDITED RESOLUTION OF APPEALS</p>	<ol style="list-style-type: none"> 1. General Requirements <ol style="list-style-type: none"> a. BHSD maintains an expedited review process for appeals when BHSD or the provider indicates that taking time for a standard resolution could seriously jeopardize the beneficiary’s mental health or substance use disorder condition, or the beneficiary’s ability to attain, maintain or regain maximum function and is deemed medically necessary. b. If BHSD denies a request for expedited resolution of an appeal, it will transfer the appeal to the timeframe for standard resolution and comply with: <ol style="list-style-type: none"> i. Make reasonable efforts to provide the beneficiary with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution. ii. Provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making



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	<p>right to file a grievance if the beneficiary disagrees with the extension.</p> <p>iii. BHSD will resolve the appeal as expeditiously as the beneficiary's health condition requires within the timeframe for standard resolution of the appeal.</p> <p>2. Timeframes for Resolving Expedited Appeals</p> <p>a. BHSD will resolve the appeal within 72 hours from receipt of the appeal.</p> <p>b. BHSD will log the time and date of appeal receipt when expedited resolution is requested because the specific time of receipt drives the timeframe for resolution.</p> <p>c. BHSD can extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations.</p> <p>3. Notice Requirements</p> <p>a. In addition to the Notice of Appeals Resolution (NAR), BHSD will make reasonable attempts to provide prompt oral notice to the beneficiary of the resolution.</p>
<p>NOTICE OF APPEAL RESOLUTION (NAR)</p>	<p>1. Adverse Benefit Determination Upheld</p> <p>a. Used for appeals that are not resolved wholly in favor of the beneficiary.</p> <p>b. BHSD will use the DHCS template or electronic equivalent from the BHSD electronic health record system.</p> <p>c. BHSD will include the NAR Your Rights attachment as part of the packet sent to the beneficiary.</p> <p>d. NARs will include:</p> <p>i. The results of the resolution and the date it was completed.</p> <p>ii. The reason for the BHSD determination, including criteria, clinical guidelines, or policies used in reaching determination.</p> <p>iii. For appeals not resolved wholly in favor of the beneficiary, the right to request a State hearing and how to request it.</p> <p>iv. . For appeals not resolved wholly in favor of the beneficiary, the right to request and</p>



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	<p>benefits while the hearing is pending and how to make that request.</p> <p>v. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the BHSD adverse benefit determination.</p> <p>2. NAR “Your Rights” Attachment provides beneficiaries with information pertaining to the NAR:</p> <ul style="list-style-type: none"> a. The beneficiary right to request a State hearing no later than 120 calendar days from the date of the BHSD written appeal resolution and instructions on how to request a State hearing. b. The beneficiary right to request and receive benefits while the State hearing is pending, instructions on how to request continuation of benefits, including the timeframe in which request shall be made. <ul style="list-style-type: none"> i. Within ten days from the date the BHSD letter was post-marked or delivered to the beneficiary. <p>3. Adverse Benefit Determination Overturned</p> <ul style="list-style-type: none"> a. Used for appeals resolved wholly in favor of the beneficiary. b. BHSD will use the DHCS template or electronic equivalent from the BHSD electronic health record system. c. BHSD will include the NAR Your Rights attachment as part of the packet sent to the beneficiary. d. NARs will include: <ul style="list-style-type: none"> i. The results of the resolution and the date it was completed. ii. The reason for the BHSD determination, including criteria, clinical guidelines, or policies used in reaching the overturned determination. e. BHSD will authorize or provide the disputed services promptly and as expeditiously as the beneficiary’s condition requires on reversal of decision to deny, limit or delay services that were not furnished while the appeal was pending.
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	<p>f. BHSD will authorize or provide services no later than 72 hours from the date and time it reverses the determination.</p>
STATE HEARINGS	<p>1. Deemed Exhaustion of Appeals Process</p> <p>a. Beneficiaries must exhaust the BHSD appeal process prior to requesting a State hearing.</p> <p>i. After receiving notice that BHSD is upholding an adverse benefit determination.</p> <p>ii. If BHSD fails to adhere to notice and timing requirements.</p> <p>2. Timeframes for Filing</p> <p>a. Beneficiaries may request a State hearing within 120 calendar days from the date of the NAR which informs the beneficiary that the Adverse Benefits Decision has been upheld.</p> <p>b. If the beneficiary is currently receiving treatment and wants to continue receiving treatment while appealing, the beneficiary must ask for the State Hearing within 10 days from the date the NAR was postmarked OR delivered or before the date Santa Clara County says services will be stopped or reduced, which ever date is later.</p> <p>c. BHSD, the beneficiary, his or her authorized representative or the representative of a deceased beneficiary estate are all parties to the State hearing.</p> <p>3. Standard Hearings</p> <p>a. BHSD will notify beneficiaries that the State must reach its decision on the hearing within 90 calendar days of the date of request for the hearing.</p> <p>4. Expedited Hearings</p> <p>a. BHSD will notify beneficiaries that the State must reach its decision on the state fair hearing within three</p>
LANGUAGE ASSISTANCE, NONDISCRIMINATION NOTICE AND TAGLINES	<p>1. Translation of Notices</p> <p>a. BHSD and providers maintain beneficiary written materials critical to obtaining services in threshold languages and alternative formats. These materials include:</p> <p>i. Appeal and grievance notices</p>



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X	Contract Providers
X	Specialty Mental Health
X	Specialty Substance Use Treatment Services

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	<ul style="list-style-type: none"> ii. Denial and termination notices 2. Nondiscrimination Notice and Language Assistance Taglines <ul style="list-style-type: none"> a. BHSD and providers post nondiscrimination notices and language assistance taglines in waiting areas and with significant communications to beneficiaries b. BHSD and BHSD providers will not modify or create new DHCS “Nondiscrimination Notice” or “Language Assistance” taglines without DHCS review and approval prior to use. c. BHSD and providers post and send nondiscrimination notices and language assistance taglines in significant communications to beneficiaries d. These templates must be sent to beneficiary in conjunction: <ul style="list-style-type: none"> i. Grievance Acknowledgement Letter ii. NOABD iii. Appeal Acknowledgement Letter iv. Grievance Resolution Letter v. Notice of Appeal Resolution
GRIEVANCE AND APPEAL SYSTEM OVERSIGHT PROCESS	<ul style="list-style-type: none"> 1. BHSD has established, implemented and maintains a Grievance and Appeal System to ensure receipt, review and resolution of grievances and appeals. <ul style="list-style-type: none"> a. Has and operates within accordance with written policies and procedures regarding its grievance and appeal system b. Notifies beneficiaries about its grievance and appeal system: <ul style="list-style-type: none"> i. Procedures for filing and resolving grievances and appeals ii. A toll-free number or local telephone number iii. Address for mailing grievances and appeals c. Maintains grievance appeal and expedited appeal forms in areas that beneficiaries can access without making verbal or written request at all sites. d. Posts the description for filing grievances and appeals in readily available locations at each plan provider site and on the BHSD website.



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	<ul style="list-style-type: none"> e. Ensures beneficiary or authorized representative assistance in filing grievances and appeals at each location where grievances and appeals are submitted. f. Grievance and appeals forms are provided promptly on request. <ol style="list-style-type: none"> 2. Employs staff who have the appropriate clinical expertise that can ensure adequate and appropriate consideration of grievances and appeals, as well as rectification when appropriate. <ul style="list-style-type: none"> a. Ensures that multiple issues are addressed and resolved. 3. Maintains a written record for each grievance and appeal received by BHSD. The log will contain: <ul style="list-style-type: none"> a. The date and time of receipt of the grievance or appeal. b. The name of the beneficiary filing the grievance or appeal. c. The name of the representative recording the grievance or appeal. d. A description of the complaint or problem. e. A description of the action taken by BHSD or the provider to investigate and resolve the grievance or appeal. f. The proposed resolution by BHSD or the provider. g. The name of the provider and staff responsible for resolving the grievance or appeal. h. The date of notification to the beneficiary of the resolution. 4. De-identified written record of grievances and appeals are submitted quarterly to the Behavioral Health Quality Improvement Committee (BHQIC) for systemic aggregation and analysis for quality improvement. <ul style="list-style-type: none"> a. Appropriate action will be taken to remedy any problems identified. 5. Grievance and appeals reviewed include but are not limited to: <ul style="list-style-type: none"> a. Access to Care b. Quality of Care c. Denial of Services
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	<p>6. BHSD ensures decision-making is done by individuals with authority to require corrective action.</p> <p>7. BHSD addresses the linguistic and cultural needs of its beneficiary population, including those needs of beneficiaries with disabilities such as visual or communicative impairments. BHSD assistance includes but is not limited to:</p> <ul style="list-style-type: none"> a. Translation of grievance and appeal procedures, forms and plan responses to grievances and appeals. b. Access to interpreters, telephone relay systems and other devices that aid individuals with disabilities to communicate. <p>8. BHSD ensures that there is no discrimination against a beneficiary because the beneficiary filed a grievance or an appeal.</p> <p>9. BHSD ensures that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal, and was not a subordinate of any individual who was involved in a previous level of review or decision-making. Additionally, the decision-maker will be a health care professional with clinical expertise in treating a beneficiaries condition or disease if any of the following apply:</p> <ul style="list-style-type: none"> a. An appeal of an Adverse Benefit Determination that is based on lack of medical necessity b. A grievance regarding denial of an expedited resolution of an appeal. c. Any grievance involving clinical issues. <p>10. BHSD ensures that individuals making decisions on clinical appeals take into account all comments, documents, records, and other information submitted by the beneficiary or the beneficiary's authorized representative, regardless of whether such information was submitted or considered in the initial Notice of Adverse Benefit Determination.</p> <p>11. BHSD provides the beneficiary or beneficiary's authorized representative the opportunity to review the beneficiary case file, including medical records, other documents or records, and any new or additional evidence considered, relied upon or generated by BHSD in connection with any standard or</p>
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	<p>expedited appeal of an Adverse Benefit Determination. This information is provided free of charge and sufficiently in advance of the resolution timeframe.</p> <p>12. BHSD provides the beneficiary or authorized representative a reasonable opportunity, in person or in writing, to present evidence and testimony. BHSD notifies the beneficiary or authorized representative of the limited time available for this sufficiently enough in advance of resolution timeframe for appeals and in the case of expedited resolution.</p> <p>13. BHSD ensures that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.</p> <p>14. BHSD is responsible for ensuring their delegates comply with applicable state and federal laws and regulations, contract requirements and other DHCS guidance. These requirements are communicated to all BHSD providers.</p>
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Responsible Party	Action Required
All Providers	<ol style="list-style-type: none"> 1. All providers are required to post notices explaining grievance, appeal, and expedited process procedures in locations at all provider and contractor sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process. 2. All providers are required to maintain Problem Resolutions Process materials in all threshold languages and make specific forms available in large type font. Materials, forms, and self-addressed envelopes must be readily available for the beneficiary to obtain without having to ask for them. The following materials are those designated to meet these requirements: <ol style="list-style-type: none"> a. BHSD Beneficiary Handbook b. Notice of Privacy Practices c. Provider Lists d. BHSD Grievance, Appeal and Expedited Appeal, poster, and handouts 3. Provide any reasonable assistance to beneficiary in completing the forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. 4. At the beneficiary's request, providers will identify staff or another individual to be responsible for assisting a beneficiary with the grievance, appeal, or expedited appeal. The identified individual should not be the same person who provide services to the beneficiary. 5. Providers will maintain their own Problem Resolution Logs which capture information about all beneficiary problem resolutions processes for tracking purposes and used to identify internal or systemic patterns. De-identified Problem Resolution Logs will be sent on a monthly basis to the



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	<p>BHSD Quality Management for quality improvement activities and state reporting requirements.</p> <p>6. Staff who make decisions on grievances and appeals must not be involved in any previous level of review or decision-making.</p> <p>7. Staff who make decisions must have the appropriate clinical expertise in treating the beneficiary's condition or disease if the decision is based on a denial of medical necessity, of an expedited appeal or the grievance involves clinical issues.</p> <p>8. Will provide any Notice of Adverse Benefit Determinations to BHSD Quality Management, so administrative staff can be alerted to a potential appeal or expedited appeal and for state reporting.</p> <p style="text-align: center;">Mental Health Division (MHD) Mental Health Call Center P.O. Box 28504 San Jose, CA 95128 (800) 704-0900 FAX (408) 885.7544</p> <p style="text-align: center;">Substance Use Treatment Services (SUTS) Quality Improvement and Data Support Division 976 Lenzen Avenue, 3rd Floor San Jose, CA 95126 (408) 792-5666 FAX (408) 947.8707</p> <p>9. Providers will make available the beneficiary's clinical record, grievance and appeal decision making materials and supporting documentation to the designated Quality Improvement Coordinator.</p> <p>10. Maintain NOABDs issued to the beneficiaries and the supporting materials in a centralized notebook for 10 years from the date the NOABD (NOA) was issued unless there are program specific requirements that demand a longer retention period.</p>
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	11. Make NOABD and Problem Resolution notebooks available to BHSD and DHCS on request.
Providers that have an internal problem resolution process	<ol style="list-style-type: none"> 1. Providers bound by regulations specific to their programs may be required to have their own problem resolution process policies and timeliness. These policies must minimally meet beneficiary rights' standards and grievance, appeal and expedited timeliness outlined by the state and these providers are not precluded from adhering to the BHSD Problem Resolution Process. 2. Providers that have their own internal grievance procedures are not precluded from the BHSD Problem Resolution Process. Beneficiaries have a right to file a grievance using the BHSD problem resolution process. Providers cannot prevent a beneficiary from filing a grievance with BHSD.
Assigned BHSD Quality Improvement Coordinator or Designated Staff	<ol style="list-style-type: none"> 1. Guides the beneficiary or authorized representative through the problem resolution process and provides information regarding the status of a beneficiary's grievance or appeal. 2. Ensures that the linguistic and cultural needs of the beneficiary are met. This includes, but is not limited to, being assigned to a staff member who speaks the beneficiary's native language, use of interpreter services, telephone relay systems and other devices that aid individuals with disabilities to communicate. 3. Enters known beneficiary information in the BHSD Problem Resolution Log within one working day of receipt. 4. Sends the beneficiary an acknowledgement letter which is to be postmarked within 5 days of receipt of the grievance. 5. Investigates the problem with the beneficiary, representative and provider in an attempt to reach a resolution. 6. Reviews the clinical record, if applicable. 7. Coordinates with QA Division Manager, Clinical Standards Coordinator or staff, BHSD Administration or County Counsel as required to obtain a resolution that is satisfactory to the beneficiary or representative. 8. Documents resolutions within the required timeframes. 9. Sends the beneficiary a Notice of Grievance Resolution once grievance is resolved.



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	<ol style="list-style-type: none"> 10. Advises beneficiary if an extension is required, verbally and in writing, within required timeframes. 11. Sends a copy of the disposition of the resolution to the provider. 12. Completes the Problem Resolution Log with final disposition, date of resolution or reason there has not been a final disposition. This log will include Inquiries and Exempt Grievances. 13. Stores problem resolution documentation in a confidential secure manner, outside of the beneficiary record, for up to 10 years after the resolution. 14. Prepares quarterly reports from the Problem Resolution Log to be reviewed by BHSD Quality Management, Administration and Behavioral Health Quality Improvement Committee (BHQIC). 15. Prepares Problem Resolution Reports for DHCS in accordance with required submission timeframes.
QUALITY IMPROVEMENT/QUALITY MANAGEMENT	<ol style="list-style-type: none"> 1. Reviews grievances/appeals prior to the disposition phase if a resolution is not reached to the satisfaction of the beneficiary. Consults with the BHSD Administration and provides a decision. 2. Analyzes the log to identify system gaps and patterns that are problematic and discusses these patterns and potential solutions with BHSD Administration and BHQI Committee.
Internal Fair Hearing Committee (for Un-sponsored Beneficiaries ONLY)	<ol style="list-style-type: none"> 1. May consist of a Quality Improvement/Quality Management staff or representative, a BHSD Advisory Board staff, and/or a clinic/agency program manager and/or a licensed clinician that are not involved with the agency in which the beneficiary has grievance or appeal concern. Under some circumstances, the BHSD Medical Director (or designee) will be included. 2. Meets with the beneficiary and County/Contractor (separately or together) to review the facts of the case, including evidence from both parties, and provides a decision. 3. Writes a letter to the beneficiary and County/Contractor for the regarding the final resolution.



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BHSD Quality Management	<ol style="list-style-type: none"> 1. All grievances and appeals shall be reviewed to identify system gaps and patterns that are problematic in order to develop corrective action for system improvement on a quarterly basis. <ol style="list-style-type: none"> a. Ensures decision-making is done by individuals with authority to require corrective action. b. Reviews grievances and appeals which include but are not limited to: <ol style="list-style-type: none"> i. Access to Care ii. Quality of Care iii. Denial of Services 2. Takes appropriate action to remedy any problems identified.
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TIMELINE STANDARDS

CATEGORY	TIMELINE	WHO
Grievances	An expression of dissatisfaction about any matter other than an NOABD.	
Filing	Any time	Beneficiaries or authorized representative
Acknowledgement	5 calendar Days	Provider or MCP
Standard Resolution	90 calendar days	Provider or MCP
Exempt Resolution	24 hours	Provider or MCP
Expedited Resolution	72 hours	Provider or MCP
Notice of Adverse Benefit Determination	A Notice Sent to Beneficiaries with regard to an action taken by the MCP which may adversely effected their services.	
Termination, Suspension, or Reduction of a previously authorized services	At least 10 days before the date of action except permitted by other State and Federal exceptions to beneficiary	Provider or MCP
Appeals	A review by an MCP of an NOABD.	
Filing	60 calendar days of date of NOABD	Beneficiaries or authorized representative
Acknowledgement	5 calendar days	MCP
Standard Resolution	30 calendar days	MCP

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Expedited Resolution	72 hours	MCP
Extension	14 calendar days	MCP
Notification of Extension	<ul style="list-style-type: none"> Reasonable efforts to provide prompt oral notice Written notice within 2 calendar days. 	MCP
Effectuation of Overturned Decisions	72 hours	MCP
Internal Fair Hearings	An equitable process to manage unsponsored beneficiary grievances and/or an appeal of a provider level grievance.	
Filing	120 days	Beneficiaries or authorized representative.
Acknowledgement	5 calendar days	Designated Investigator
Standard Resolution	30 calendar days	Designated Investigator
Expedited Resolution	72 hours	Designated Investigator
Extension	14 calendar days	Designated Investigator
Notification of Extension	<ul style="list-style-type: none"> Reasonable efforts to provide prompt oral notice Written notice within 2 calendar days. 	Designated Investigator
State Hearings	In response to Notice of Appeal Resolution.	
Filing	120 days from NAR	Beneficiary or authorized representative
Standard Resolution	90 calendar days	State Hearings Division
Expedited Resolution	3 working days	State Hearings Division
Effectuation of Overturned Decisions	72 hours	State Hearings Division



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1. Attachments	<ol style="list-style-type: none">1. Notice of Grievance Resolution (NGR)2. Denial Notice (NOABD)3. Payment Denial Notice (NOABD)4. Delivery System Notice (NOABD)5. Modification Notice (NOABD)6. Termination Notice (NOABD)7. Timely Access (NOABD)8. Financial Liability (NOABD)9. NOABD "Your Rights" Attachment10. Notice of Appeal Resolution - Determination Upheld (NAR)11. NAR "Your Rights" Attachment12. Notice of Appeal Resolution - Determination Overturned (NAR)13. Beneficiary Non-Discrimination Notice14. Language Assistance Taglines
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Approved/Issue Date:	Behavioral Health Services Director: Toni Tullys	
Last Review/Revision Date: 3/13/2018	Next Review Date: 3/13/2022	Inactive Date:

<p><u>REFERENCE:</u></p> <ul style="list-style-type: none"> • 42 CFR §§ 431.211-214 Notice. • 42 C.F.R. § 431.220 When a Hearing Is Required. • 42 CFR § 431.244(f) Expedited Appeals. • 42 CFR § 438 Managed Care. • 42 CFR § 438, Subpart F Grievance and Appeal System. • 42 CFR § 438.10 Information Requirements. • 42 CFR § 438.228 Grievance and Appeals Systems. • 42 CFR § 438.400 (b) Statutory Basis, Definitions, and Applicability. • 42 CFR §§ 438.402 (b) - (c) General Requirements. • 42 CFR §§ 438.404 (b)-(c) Timely and Adequate Notice of Adverse Benefit Determination. • 42 CFR §§ 438.406 (a)-(b) Handling of Grievances and Appeals. • 42 CFR §§ 438.408(b)-(f) Resolution and notification: Grievances and appeals. • 42 CFR § 438.410 (c) Expedited resolution of appeals. • 42 CFR § 438.414 • 42 CFR § 438.416 (b) Recordkeeping requirements. • 42 CFR § 438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending. • 42 CFR § 438.424(a) Effectuation of reversed appeal resolutions. • 45 CFR § 92.8 Notice requirement. • 81 FR 27497 Medicaid and Children's Health Insurance Program (Chip) Programs; Medicaid Managed Care, Chip Delivered In Managed Care, and Revisions Related to Third Party Liability. • 81 FR § 31375 Nondiscrimination in Health Programs and Activities • 9 CCR § 1810.200 Action. • 9 CCR § 1810.230.5 Notice of Action. • 9 CCR § 1810.216.2 Expedited Appeal. • 9 CCR § 1810.216.4 Expedited Fair Hearing. • 9 CCR §1810.440 MHP Quality Management Programs.
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- 9 CCR §1820.100 Definitions.
- 9 CCR §1830.100 General Provisions.
- 9 CCR §1830.205 Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.
- 9 CCR §1830.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.
- 9 CCR §§1850.205-1850.215 Beneficiary Problem Resolution Processes.
- 22 CCR § 51014.1-2 Medical Assistance Pending Fair Hearing Decision.
- 22 CCR § 50179. Notice of Action Medi-Cal-Only Determinations or Redeterminations.
- 22 CCR § 53858 (e) Member Grievance Procedures.
- 28 CCR § 1300.67.04 Language Assistance Programs.
- 28 CCR §1300.68(a) Grievance System.
- HSC §1367.01 Health Care Service Plans.
- HSC §1368 Grievance System
- DHCS All Plan Letter 17-006
- DHCS Information Notice: 18-010
- Beneficiary Request for Second Opinion BHSD# 11200.1
- Beneficiary Request for Second Opinion SUTS BHSD# 11200.2

POLICY:

Beneficiaries that receive BHSD services may file a grievance or appeal and have their concerns addressed through a clearly defined problem resolution process if they are not satisfied with their behavioral health services or steps taken by BHSD. Behavioral Health Services Department for the County of Santa Clara has a three-tiered resolution process:

1. The Provider level, beneficiaries or beneficiary representatives are encouraged to resolve concerns at the program level where services are received,
2. The BHSD Plan level, beneficiary may submit a formal grievance and/or appeal to the MCP.
 - a. An internal hearing (for uninsured beneficiaries only) is available if beneficiaries are not satisfied with the result of their grievance and appeal.
3. The State Fair Hearings Division (for Medi-Cal beneficiary's only).
 - a. Beneficiaries and beneficiary representatives are required to exhaust the BHSD problem resolution process prior to filing for a State Fair Hearing.
4. Internal Fair Hearing (for uninsured beneficiaries only)
 - a. Beneficiaries and beneficiary representatives are required to exhaust the BHSD



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problem resolution process prior to filing for an Internal Fair Hearing.

BHSD service beneficiaries have rights specific to:

1. File a grievance/appeal orally or in writing in the language of their choice.
2. Authorize another person, a representative, to act on their behalf.
3. To obtain a second opinion (refer to Beneficiary Request for Second Opinion BHSD# and Beneficiary Request for Second Opinion BHSD# 11200.2)
 - a) Beneficiaries can delay their grievance/appeal pending the outcome of the second opinion or proceed with both processes at the same time.
4. At any stage of the problem resolution process, the beneficiary may access:
 - a) The DHCS MMCO “Medi-Cal Managed Care Office of Ombudsman” as a neutral advocate to answer questions. These services are available M – F 8a.m. to 5 p.m. PST at 1-888-452-8609.
 - b) For mental health service questions, additional support may also be obtained from one or more beneficiary advocates, including Mental Health Advocacy Project at 408-294-9730 or 800-248-6427 x420, or Disability Rights California for legal assistance at 800-776-5746.
 - c) For substance use services questions, additional support may be obtained at the SUTS Benefits Line (408)-792-5666.
5. Beneficiaries and their representative (with proper consent), before and during the appeals process, may examine the beneficiary’s clinical record and any other documents and records to be considered during the appeal process. This information will be provided free of charge and sufficiently in advance of the resolution timeframe.
6. Beneficiaries will be given a reasonable opportunity to present evidence in person as well as in writing.
7. All grievances, appeals, and expedited appeals will be resolved within the established timeframes and any required notice of an extension is given. See Timeliness Standards Section.
8. Will not be subject to discrimination or any other penalty or punitive action for filing a grievance, appeal, or expedited appeal.
9. Confidentiality will be maintained throughout the beneficiary resolution process.
10. Beneficiaries may request BHSD assistance in preparing a written appeal.
11. In the event BHSD does not receive a written, signed Appeal from the beneficiary, BHSD will neither dismiss nor delay resolution of the Appeal.
12. Beneficiaries or their representatives have the right to request a State Fair Hearing if BHSD fails to send a resolution notice in response to an Appeal within the required



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timeframe.

13. BHSD’s beneficiary problem resolution process will not replace or conflict with the duties of beneficiary’s rights advocates.

BHSD providers contracted to provide services must inform beneficiaries when those services will be reduced, limited, denied or modified. The mechanism to notify beneficiaries is called a Notice of Adverse Benefit Determination, NOABD. This policy describes the situations that warrant a NOABD and the process through which a NOABD is issued to ensure accordance with State regulations, so that beneficiaries are able to exercise their rights in response to a NOABD

BHSD delegates submission of certain NOABD’s to providers as follows:

When the Provider:

1. Is unable to meet timely access standards
2. Must modify a service requested by a beneficiary.
3. Must terminate a beneficiary service;

When the Beneficiary:

4. Does not meet medical necessity criteria
5. Requests a service that is not covered
6. Asks for payment to be approved for a service which was received that BHSD does not cover.
7. Disputes financial liability such as cost-sharing or co-insurance.

DEFINITIONS:

Appeal. A review by BHSD or Contract Agency of an adverse benefit determination.

Beneficiary. A Medi-Cal recipient who is currently receiving services from BHSD or a BHSD contracted provider.

Grievance. An expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary’s rights regardless of whether remedial action



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is requested. Grievance includes a beneficiary’s right to dispute an extension of time proposed by BHSD to make an authorization decision. (42 C.F.R. § 438.400)

Provider. A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.

PROCEDURE	
Processes	Mandated Requirements
GRIEVANCES	<ol style="list-style-type: none"> 1. Timeframes for filing <ol style="list-style-type: none"> a. At any time 2. Method of filing <ol style="list-style-type: none"> a. Orally or in writing 3. Who may file <ol style="list-style-type: none"> a. Beneficiary b. Authorized representative c. Provider on behalf of the beneficiary 4. Standard Grievances <ol style="list-style-type: none"> a. Acknowledgement <ol style="list-style-type: none"> i. In writing ii. Postmarked within 5 calendar days of receipt of grievance b. Resolution <ol style="list-style-type: none"> i. Within an established timeframe of 90 calendar days for resolution of grievances except: <ol style="list-style-type: none"> 1. Grievances related to disputes of the MCP’s decision to extend the timeframe for making an



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	<p>authorization decision will not exceed 30 calendar days.</p> <ul style="list-style-type: none"> ii. Complete and send the Notice of Grievance Resolution (NGR) template to notify beneficiaries of the results of the grievance resolution. <ul style="list-style-type: none"> 1. NGR will contain a clear and concise explanation of the decision. <p>c. Extensions</p> <ul style="list-style-type: none"> i. Can be extended an additional 14 calendar days: <ul style="list-style-type: none"> 1. Beneficiary requests 2. Plan shows a need for additional information and how the delay is in the beneficiary's interest. ii. Provide beneficiary with the applicable NOABD, include status of grievance, estimated date of resolution, which will not exceed 14 additional calendar days. iii. If BHSD extends the timeframe for any grievances that wasn't requested by the beneficiary, BHSD makes reasonable efforts to give the beneficiary prompt oral notice of the delay and give the beneficiary written notice of the extension and the reasons for the extension within 2 calendar days of the decision to extend the timeframe. <ul style="list-style-type: none"> 1. The written notice of extension shall inform the beneficiary of the right to file a grievance if beneficiary disagrees with the BHSD's decision <p>d. Grievance Process Exemptions</p> <ul style="list-style-type: none"> i. Grievances received over the telephone or in person that are resolved to the beneficiaries satisfaction by the close of the next business day following receipt are
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	<p>exempt from the written acknowledgement and disposition letters.</p> <ul style="list-style-type: none"> ii. Grievances received via mail are not exempt from requirement to send acknowledgement and disposition letters. iii. Complaints pertaining to a Notice of Adverse Benefit determination is not considered a grievance and the exemption does not apply. <p>e. Grievance Logs</p> <ul style="list-style-type: none"> i. Must maintain a log of all grievances, including the date of receipt of the grievance, the name of the beneficiary, nature of the grievances, the resolutions and the representative's name who received and resolved the grievances. This includes exempt grievances. ii. Must transmit de-identified information that describe issues identified as the result of the grievance, appeal or expedited appeals processes to the BHSD's administration and/or Quality Improvement Committee for quality improvement purposes. <p>2.</p>
<p>Notice of Adverse Benefit Determinations</p>	<p>1. Written Notice of Adverse Benefit Determination Requirements must explain:</p> <ul style="list-style-type: none"> a. The adverse benefit determination that has been or will be made. b. A clear and concise explanation of the reason(s) for the decision. <ul style="list-style-type: none"> i. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision and the right to a second opinion. ii. Will explicitly state why the beneficiary's condition does not meet specialty mental health services and/or DMC-ODS medical necessity criteria.



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	<ul style="list-style-type: none"> c. A description of the criteria used. This includes medical necessity criteria and any processes, strategies or evidentiary standards used in making such determinations. d. The beneficiary's right to be provided on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination. e. NOABD must include the name and the direct telephone number or extension of the decision-maker. f. Decisions may be communicated to providers initially by telephone or facsimile and then in writing, except decisions rendered retrospectively. <p>2. Timing of Notice</p> <ul style="list-style-type: none"> a. For termination, suspension or reduction of a previously authorized specialty mental health and/or DMC-ODS service, at least 10 days before the date of the action. b. For denial of payment, at the time of any action denying a provider's claim. c. For decisions resulting in the denial, delay or modification of all or part of the requested specialty mental health and/or DMC-ODS services, within two business days of the decision. <p>3. Advance Notice Exemptions</p> <ul style="list-style-type: none"> a. The Plan is exempt from sending an advance notice when: <ul style="list-style-type: none"> i. The provider has factual information confirming the death of a beneficiary. ii. The provider receives a clear written statement signed by the beneficiary that: <ul style="list-style-type: none"> 1. They no longer want services 2. Gives information that requires termination or reduction of services and indicates they understand this
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	<p>must be the result of supplying the information.</p> <ul style="list-style-type: none"> iii. Beneficiary has been admitted to an institution where they are ineligible under the plan for further services. iv. Beneficiary whereabouts are unknown and/or post office returns agency mail directed to the beneficiary indicating no forwarding address v. Plan establishes that the beneficiary has been accepted for Medicaid services by another jurisdiction, state, territory or commonwealth. vi. . A change in the level of care is prescribed by the beneficiary’s physician. vii. The notice involves an adverse determination made with regard to preadmission screening requirements. <p>b. Advance Notice Exceptions date of action will occur in less than 10 days.</p>
<p>Written NOABD Templates</p>	<ol style="list-style-type: none"> 1. Must use DHCS uniform notice templates or the electronic equivalent of these templates generated from the provider electronic health record system. 2. Notice templates include both the NOABD and “Your Rights” documents. 3. DENIAL template is used when the MCP denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. For DMC-ODS pilot counties, also use this template for denied residential service requests. 4. PAYMENT DENIAL Template for is used when the MCP denies, in whole or in part, for any reason, a provider’s request for payment for a service that has already been delivered to a beneficiary. 5. DELIVERY SYSTEM template is used when the MCP has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder



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	<p>services through the plan. The beneficiary will be referred to the managed health care plan, or other appropriate system, for mental health, substance use disorder, or other services.</p> <p>6. MODIFICATION template is used when the Plan modifies or limits a provider’s request for a service including reductions in frequency and/or duration of services and approval of alternative treatments and services.</p> <p>7. TERMINATION template is used when the plan terminates, reduces or suspends a previously authorized service.</p> <p>8. TIMELY ACCESS template is used when there is a delay processing a provider’s and/or beneficiary’s request for authorization of specialty mental health services or substance use disorder residential services. When the plan extends the timeframe to make an authorization decision, it is a delay in processing a provider’s and/or beneficiary’s request. This includes extensions granted at the request of the beneficiary or provider and/or those granted when there is a need for additional information from the beneficiary or provider when the extension is in the beneficiary interest.</p> <p>9. TIMELY ACCESS template is used when there is a delay in providing the beneficiary with timely services as required by timely access standards applicable to the delayed service.</p> <p>10. FINANCIAL LIABILITY template is used when the plan denies a beneficiary’s request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.</p>
<p>NOABD “Your Rights” Attachment</p>	<p>1. Provides beneficiaries with information related to the NOABD:</p> <ul style="list-style-type: none"> a. The beneficiary or provider right to request an internal appeal with the Plan within 60 calendar days from the date on the NOABD. b. The beneficiary right to request a State hearing only after filing an appeal with the Plan and receiving a Notice that Adverse Benefit Determination has been upheld. c. The beneficiary right to request a State hearing if the Plan fails to send a resolution notice in response to the appeal within the required timeframe.



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	<ul style="list-style-type: none"> d. Procedures for exercising the beneficiary’s rights to request an appeal. e. Circumstances under which an expedited review is available and how to request it. f. The beneficiaries’ right to have benefits continue pending resolution of the appeal and how to request continuation of benefits. <ol style="list-style-type: none"> 2. Utilize the Your Rights attachment template or attachments generated from the provider electronic health record system. 3. Will not alter or change template without prior review and approval from DHCS with the exception of insertion of information specific to beneficiaries’ as required.
<p>APPEALS</p>	<ol style="list-style-type: none"> 1. Timeframes for filing <ul style="list-style-type: none"> a. Beneficiaries must file an appeal within 60 calendar days from the date on the NOABD. 2. Who can file <ul style="list-style-type: none"> a. Beneficiary b. Authorized representative c. Provider on behalf of the beneficiary with a written authorization from the beneficiary 3. Method of filing <ul style="list-style-type: none"> a. Orally b. In writing c. Appeals filed by provider on behalf of beneficiary require written beneficiary consent. d. Oral requests for standards appeals shall be followed by a written appeal signed by the beneficiary and confirmation of receipt of appeal. e. BHSD and BHSD providers shall assist beneficiary in completing forms and taking other procedural steps to file an appeal including preparing a written appeal, notifying beneficiary of the location of the form on the BHSD website or providing the form to the beneficiary on request. f. BHSD and providers will advise and assist the beneficiary in requesting continuation of benefits during an appeal of an adverse benefit determination.



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	<p style="margin-left: 40px;">g. In the event that BHSD does not receive a written, signed appeal from the beneficiary, BHSD will not dismiss or delay resolution of the appeal.</p> <p>4. Authorized Representatives</p> <p style="margin-left: 20px;">a. With written consent from the beneficiary, a provider or authorized representative may file a grievance, request an appeal or request a State hearing on behalf of a beneficiary.</p> <p style="margin-left: 20px;">b. Only the beneficiary can request continuation of benefits.</p> <p>5. Standard Resolution of Appeals</p> <p style="margin-left: 20px;">a. Acknowledgement</p> <p style="margin-left: 40px;">i. BHSD will provide written acknowledgement of receipt of the appeal.</p> <p style="margin-left: 40px;">ii. Acknowledgement letter will include:</p> <p style="margin-left: 60px;">1. Date of receipt</p> <p style="margin-left: 60px;">2. Name, telephone number and address of the BHSD representative who the beneficiary may contact about the appeal.</p> <p style="margin-left: 40px;">iii. Must be postmarked within five calendar days of receipt of the appeal.</p> <p style="margin-left: 20px;">b. Standard Resolution Timeframe</p> <p style="margin-left: 40px;">i. Must be resolved within 30 days of receipt.</p> <p style="margin-left: 20px;">c. Extension Timeframes</p> <p style="margin-left: 40px;">i. BHSD may extend timeframes for appeals by up to 14 calendar days if either of the two conditions apply:</p> <p style="margin-left: 60px;">ii. The beneficiary requests an extension.</p> <p style="margin-left: 40px;">iii. BHSD demonstrates to the satisfaction of DHCS, on request, that there is a need for additional information and how the delay is in the beneficiary's best interest.</p> <p style="margin-left: 60px;">1. BHSD must provide written notice of the reason for a delay not requested by the beneficiary.</p>
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	<ol style="list-style-type: none"> 2. BHSD will make reasonable efforts to provide the beneficiary with prompt oral notice of the extension. 3. BHSD will provide written notice of the extension within two calendar days of making the decision to extend the timeframe and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension. 4. BHSD will resolve the appeal as expeditiously as the beneficiary’s health condition requires and in no event extend the resolution beyond the 14 calendar day extension. 5. In the event that BHSD fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the BHSD appeal process and may initiate a State hearing.
<p>EXPEDITED RESOLUTION OF APPEALS</p>	<ol style="list-style-type: none"> 1. General Requirements <ol style="list-style-type: none"> a. BHSD maintains an expedited review process for appeals when BHSD or the provider indicates that taking time for a standard resolution could seriously jeopardize the beneficiary’s mental health or substance use disorder condition, or the beneficiary’s ability to attain, maintain or regain maximum function. b. If BHSD denies a request for expedited resolution of an appeal, it will transfer the appeal to the timeframe for standard resolution and comply with: <ol style="list-style-type: none"> i. Make reasonable efforts to provide the beneficiary with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution. ii. Provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making the decision and notify the beneficiary of the



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	<p>right to file a grievance if the beneficiary disagrees with the extension.</p> <p>iii. BHSD will resolve the appeal as expeditiously as the beneficiary's health condition requires within the timeframe for standard resolution of the appeal.</p> <p>2. Timeframes for Resolving Expedited Appeals</p> <p>a. BHSD will resolve the appeal within 72 hours from receipt of the appeal.</p> <p>b. BHSD will log the time and date of appeal receipt when expedited resolution is requested because the specific time of receipt drives the timeframe for resolution.</p> <p>c. BHSD can extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations.</p> <p>3. Notice Requirements</p> <p>a. In addition to the Notice of Appeals Resolution (NAR), BHSD will make reasonable attempts to provide prompt oral notice to the beneficiary of the resolution.</p>
<p>NOTICE OF APPEAL RESOLUTION (NAR)</p>	<p>1. Adverse Benefit Determination Upheld</p> <p>a. Used for appeals that are not resolved wholly in favor of the beneficiary.</p> <p>b. BHSD will use the DHCS template or electronic equivalent from the BHSD electronic health record system.</p> <p>c. BHSD will include the NAR Your Rights attachment as part of the packet sent to the beneficiary.</p> <p>d. NARs will include:</p> <p>i. The results of the resolution and the date it was completed.</p> <p>ii. The reason for the BHSD determination, including criteria, clinical guidelines, or policies used in reaching determination.</p> <p>iii. For appeals not resolved wholly in favor of the beneficiary, the right to request a State hearing and how to request it.</p> <p>iv. . For appeals not resolved wholly in favor of the beneficiary, the right to request and</p>



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	<p>benefits while the hearing is pending and how to make that request.</p> <ul style="list-style-type: none"> v. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the BHSD adverse benefit determination. <p>2. NAR “Your Rights” Attachment provides beneficiaries with information pertaining to the NAR:</p> <ul style="list-style-type: none"> a. The beneficiary right to request a State hearing no later than 120 calendar days from the date of the BHSD written appeal resolution and instructions on how to request a State hearing. b. The beneficiary right to request and receive benefits while the State hearing is pending, instructions on how to request continuation of benefits, including the timeframe in which request shall be made. <ul style="list-style-type: none"> i. Within ten days from the date the BHSD letter was post-marked or delivered to the beneficiary. <p>3. Adverse Benefit Determination Overturned</p> <ul style="list-style-type: none"> a. Used for appeals resolved wholly in favor of the beneficiary. b. BHSD will use the DHCS template or electronic equivalent from the BHSD electronic health record system. c. BHSD will include the NAR Your Rights attachment as part of the packet sent to the beneficiary. d. NARs will include: <ul style="list-style-type: none"> i. The results of the resolution and the date it was completed. ii. The reason for the BHSD determination, including criteria, clinical guidelines, or policies used in reaching the overturned determination. e. BHSD will authorize or provide the disputed services promptly and as expeditiously as the beneficiary’s condition requires on reversal of decision to deny, limit or delay services that were not furnished while the appeal was pending.
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	<p>f. BHSD will authorize or provide services no later than 72 hours from the date and time it reverses the determination.</p>
STATE HEARINGS	<ol style="list-style-type: none"> 1. Deemed Exhaustion of Appeals Process <ol style="list-style-type: none"> a. Beneficiaries must exhaust the BHSD appeal process prior to requesting a State hearing. <ol style="list-style-type: none"> i. After receiving notice that BHSD is upholding an adverse benefit determination. ii. If BHSD fails to adhere to notice and timing requirements. 2. Timeframes for Filing <ol style="list-style-type: none"> a. Beneficiaries may request a State hearing within 120 calendar days from the date of the NAR which informs the beneficiary that the Adverse Benefits Decision has been upheld. b. BHSD, the beneficiary, his or her authorized representative or the representative of a deceased beneficiary estate are all parties to the State hearing. 3. Standard Hearings <ol style="list-style-type: none"> a. BHSD will notify beneficiaries that the State must reach its decision on the hearing within 90 calendar days of the date of request for the hearing. 4. Expedited Hearings <ol style="list-style-type: none"> a. BHSD will notify beneficiaries that the State must reach its decision on the state fair hearing within three working days of the date of the request for the hearing. 5. Overturned Decisions <ol style="list-style-type: none"> a. BHSD will authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the BHSD adverse benefits determination.
LANGUAGE ASSISTANCE, NONDISCRIMINATION NOTICE AND TAGLINES	<ol style="list-style-type: none"> 1. Translation of Notices <ol style="list-style-type: none"> a. BHSD and providers maintain beneficiary written materials critical to obtaining services in threshold languages and alternative formats. These materials include: <ol style="list-style-type: none"> i. Appeal and grievance notices



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	<ul style="list-style-type: none"> ii. Denial and termination notices 2. Nondiscrimination Notice and Language Assistance Taglines <ul style="list-style-type: none"> a. BHSD and providers post nondiscrimination notices and language assistance taglines in waiting areas and with significant communications to beneficiaries b. BHSD and BHSD providers will not modify or create new DHCS “Nondiscrimination Notice” or “Language Assistance” taglines without DHCS review and approval prior to use. c. BHSD and providers post and send nondiscrimination notices and language assistance taglines in significant communications to beneficiaries d. These templates must be sent to beneficiary in conjunction: <ul style="list-style-type: none"> i. Grievance Acknowledgement Letter ii. NOABD iii. Appeal Acknowledgement Letter iv. Grievance Resolution Letter v. Notice of Appeal Resolution
GRIEVANCE AND APPEAL SYSTEM OVERSIGHT PROCESS	<ul style="list-style-type: none"> 1. BHSD has established, implemented and maintains a Grievance and Appeal System to ensure receipt, review and resolution of grievances and appeals. <ul style="list-style-type: none"> a. Has and operates within accordance with written policies and procedures regarding its grievance and appeal system b. Notifies beneficiaries about its grievance and appeal system: <ul style="list-style-type: none"> i. Procedures for filing and resolving grievances and appeals ii. A toll-free number or local telephone number iii. Address for mailing grievances and appeals c. Maintains grievance appeal and expedited appeal forms in areas that beneficiaries can access without making verbal or written request at all sites. d. Posts the description for filing grievances and appeals in readily available locations at each plan provider site and on the BHSD website.



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	<ul style="list-style-type: none">e. Ensures beneficiary or authorized representative assistance in filing grievances and appeals at each location where grievances and appeals are submitted.f. Grievance and appeals forms are provided promptly on request. <p>2. Employs staff who have the appropriate clinical expertise that can ensure adequate and appropriate consideration of grievances and appeals, as well as rectification when appropriate.</p> <ul style="list-style-type: none">a. Ensures that multiple issues are addressed and resolved. <p>3. Maintains a written record for each grievance and appeal received by BHSD. The log will contain:</p> <ul style="list-style-type: none">a. The date and time of receipt of the grievance or appeal.b. The name of the beneficiary filing the grievance or appeal.c. The name of the representative recording the grievance or appeal.d. A description of the complaint or problem.e. A description of the action taken by BHSD or the provider to investigate and resolve the grievance or appeal.f. The proposed resolution by BHSD or the provider.g. The name of the provider and staff responsible for resolving the grievance or appeal.h. The date of notification to the beneficiary of the resolution. <p>4. De-identified written record of grievances and appeals are submitted quarterly to the Behavioral Health Quality Improvement Committee (BHQIC) for systemic aggregation and analysis for quality improvement.</p> <ul style="list-style-type: none">a. Appropriate action will be taken to remedy any problems identified. <p>5. Grievance and appeals reviewed include but are not limited to:</p> <ul style="list-style-type: none">a. Access to Careb. Quality of Carec. Denial of Services
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	<p>6. BHSD ensures decision-making is done by individuals with authority to require corrective action.</p> <p>7. BHSD addresses the linguistic and cultural needs of its beneficiary population, including those needs of beneficiaries with disabilities such as visual or communicative impairments. BHSD assistance includes but is not limited to:</p> <ul style="list-style-type: none"> a. Translation of grievance and appeal procedures, forms and plan responses to grievances and appeals. b. Access to interpreters, telephone relay systems and other devices that aid individuals with disabilities to communicate. <p>8. BHSD ensures that there is no discrimination against a beneficiary because the beneficiary filed a grievance or an appeal.</p> <p>9. BHSD ensures that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal, and was not a subordinate of any individual who was involved in a previous level of review or decision-making. Additionally, the decision-maker will be a health care professional with clinical expertise in treating a beneficiaries condition or disease if any of the following apply:</p> <ul style="list-style-type: none"> a. An appeal of an Adverse Benefit Determination that is based on lack of medical necessity b. A grievance regarding denial of an expedited resolution of an appeal. c. Any grievance involving clinical issues. <p>10. BHSD ensures that individuals making decisions on clinical appeals take into account all comments, documents, records, and other information submitted by the beneficiary or the beneficiary's authorized representative, regardless of whether such information was submitted or considered in the initial Notice of Adverse Benefit Determination.</p> <p>11. BHSD provides the beneficiary or beneficiary's authorized representative the opportunity to review the beneficiary case file, including medical records, other documents or records, and any new or additional evidence considered, relied upon or generated by BHSD in connection with any standard or</p>
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	<p>expedited appeal of an Adverse Benefit Determination. This information is provided free of charge and sufficiently in advance of the resolution timeframe.</p> <p>12. BHSD provides the beneficiary or authorized representative a reasonable opportunity, in person or in writing, to present evidence and testimony. BHSD notifies the beneficiary or authorized representative of the limited time available for this sufficiently enough in advance of resolution timeframe for appeals and in the case of expedited resolution.</p> <p>13. BHSD ensures that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.</p> <p>14. BHSD is responsible for ensuring their delegates comply with applicable state and federal laws and regulations, contract requirements and other DHCS guidance. These requirements are communicated to all BHSD providers.</p>
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Responsible Party	Action Required
<p>All Providers</p>	<ol style="list-style-type: none"> 1. All providers are required to post notices explaining grievance, appeal, and expedited process procedures in locations at all provider and contractor sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process. 2. All providers are required to maintain Problem Resolutions Process materials in all threshold languages and make specific forms available in large type font. Materials, forms, and self-addressed envelopes must be readily available for the beneficiary to obtain without having to ask for them. The following materials are those designated to meet these requirements: <ol style="list-style-type: none"> a. BHSD Beneficiary Handbook b. Notice of Privacy Practices c. Provider Lists d. BHSD Grievance, Appeal and Expedited Appeal, poster, and handouts 3. Provide any reasonable assistance to beneficiary in completing the forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. 4. At the beneficiary's request, providers will identify staff or another individual to be responsible for assisting a beneficiary with the grievance, appeal, or expedited appeal. The identified individual should not be the same person who provide services to the beneficiary. 5. Providers will maintain their own Problem Resolution Logs which capture information about all beneficiary problem resolutions processes for tracking purposes and used to identify internal or systemic patterns. De-identified Problem Resolution Logs will be sent on a monthly basis to the



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	<p>BHSD Quality Management for quality improvement activities and state reporting requirements.</p> <p>6. Staff who make decisions on grievances and appeals must not be involved in any previous level of review or decision-making.</p> <p>7. Staff who make decisions must have the appropriate clinical expertise in treating the beneficiary's condition or disease if the decision is based on a denial of medical necessity, of an expedited appeal or the grievance involves clinical issues.</p> <p>8. Will provide any Notice of Adverse Benefit Determinations to BHSD Quality Management, so administrative staff can be alerted to a potential appeal or expedited appeal and for state reporting.</p> <p style="text-align: center;">Mental Health Division (MHD) Mental Health Call Center P.O. Box 28504 San Jose, CA 95128 (800) 704-0900 FAX (408) 885.7544</p> <p style="text-align: center;">Substance Use Treatment Services (SUTS) Quality Improvement and Data Support Division 976 Lenzen Avenue, 3rd Floor San Jose, CA 95126 (408) 792-5666 FAX (408) 947.8707</p> <p>9. Providers will make available the beneficiary's clinical record, grievance and appeal decision making materials and supporting documentation to the designated Quality Improvement Coordinator.</p> <p>10. Maintain NOABDs issued to the beneficiaries and the supporting materials in a centralized notebook for 10 years from the date the NOABD (NOA) was issued unless there are program specific requirements that demand a longer retention period.</p>
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	11. Make NOABD and Problem Resolution notebooks available to BHSD and DHCS on request.
Providers that have an internal problem resolution process	<ol style="list-style-type: none"> 1. Providers bound by regulations specific to their programs may be required to have their own problem resolution process policies and timeliness. These policies must minimally meet beneficiary rights' standards and grievance, appeal and expedited timeliness outlined by the state and these providers are not precluded from adhering to the BHSD Problem Resolution Process. 2. Providers that have their own internal grievance procedures are not precluded from the BHSD Problem Resolution Process. Beneficiaries have a right to file a grievance using the BHSD problem resolution process. Providers cannot prevent a beneficiary from filing a grievance with BHSD.
Assigned BHSD Quality Improvement Coordinator or Designated Staff	<ol style="list-style-type: none"> 1. Guides the beneficiary or authorized representative through the problem resolution process and provides information regarding the status of a beneficiary's grievance or appeal. 2. Ensures that the linguistic and cultural needs of the beneficiary are met. This includes, but is not limited to, being assigned to a staff member who speaks the beneficiary's native language, use of interpreter services, telephone relay systems and other devices that aid individuals with disabilities to communicate. 3. Enters known beneficiary information in the BHSD Problem Resolution Log within one working day of receipt. 4. Sends the beneficiary an acknowledgement letter which is to be postmarked within 5 days of receipt of the grievance. 5. Investigates the problem with the beneficiary, representative and provider in an attempt to reach a resolution. 6. Reviews the clinical record, if applicable. 7. Coordinates with QA Division Manager, Clinical Standards Coordinator or staff, BHSD Administration or County Counsel as required to obtain a resolution that is satisfactory to the beneficiary or representative. 8. Documents resolutions within the required timeframes. 9. Sends the beneficiary a Notice of Grievance Resolution once grievance is resolved.



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<input checked="" type="checkbox"/>	BHSD County Staff
<input checked="" type="checkbox"/>	Contract Providers
<input checked="" type="checkbox"/>	Specialty Mental Health
<input checked="" type="checkbox"/>	Specialty Substance Use Treatment Services

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	<ol style="list-style-type: none"> 10. Advises beneficiary if an extension is required, verbally and in writing, within required timeframes. 11. Sends a copy of the disposition of the resolution to the provider. 12. Completes the Problem Resolution Log with final disposition, date of resolution or reason there has not been a final disposition. This log will include Inquiries and Exempt Grievances. 13. Stores problem resolution documentation in a confidential secure manner, outside of the beneficiary record, for up to 10 years after the resolution. 14. Prepares quarterly reports from the Problem Resolution Log to be reviewed by BHSD Quality Management, Administration and Behavioral Health Quality Improvement Committee (BHQIC). 15. Prepares Problem Resolution Reports for DHCS in accordance with required submission timeframes.
QUALITY IMPROVEMENT/QUALITY MANAGEMENT	<ol style="list-style-type: none"> 1. Reviews grievances/appeals prior to the disposition phase if a resolution is not reached to the satisfaction of the beneficiary. Consults with the BHSD Administration and provides a decision. 2. Analyzes the log to identify system gaps and patterns that are problematic and discusses these patterns and potential solutions with BHSD Administration and BHQI Committee.
Internal Fair Hearing Committee (for Un-sponsored Beneficiaries ONLY)	<ol style="list-style-type: none"> 1. May consist of a Quality Improvement/Quality Management staff or representative, a BHSD Advisory Board staff, and/or a clinic/agency program manager and/or a licensed clinician that are not involved with the agency in which the beneficiary has grievance or appeal concern. Under some circumstances, the BHSD Medical Director (or designee) will be included. 2. Meets with the beneficiary and County/Contractor (separately or together) to review the facts of the case, including evidence from both parties, and provides a decision. 3. Writes a letter to the beneficiary and County/Contractor for the regarding the final resolution.



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X	BHSD County Staff
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BHSD Quality Management	<ol style="list-style-type: none"> 1. All grievances and appeals shall be reviewed to identify system gaps and patterns that are problematic in order to develop corrective action for system improvement on a quarterly basis. <ol style="list-style-type: none"> a. Ensures decision-making is done by individuals with authority to require corrective action. b. Reviews grievances and appeals which include but are not limited to: <ol style="list-style-type: none"> i. Access to Care ii. Quality of Care iii. Denial of Services 2. Takes appropriate action to remedy any problems identified.
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TIMELINE STANDARDS

CATEGORY	TIMELINE	WHO
Grievances	An expression of dissatisfaction about any matter other than an NOABD.	
Filing	Any time	Beneficiaries or authorized representative
Acknowledgement	5 calendar Days	Provider or MCP
Standard Resolution	90 calendar days	Provider or MCP
Exempt Resolution	24 hours	Provider or MCP
Expedited Resolution	72 hours	Provider or MCP
Notice of Adverse Benefit Determination	A Notice Sent to Beneficiaries with regard to an action taken by the MCP which may adversely effected their services.	
Termination, Suspension, or Reduction of a previously authorized services	At least 10 days before the date of action except permitted by other State and Federal exceptions to beneficiary	Provider or MCP
Appeals	A review by an MCP of an NOABD.	
Filing	60 calendar days of date of NOABD	Beneficiaries or authorized representative
Acknowledgement	5 calendar days	MCP
Standard Resolution	30 calendar days	MCP



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Expedited Resolution	72 hours	MCP
Extension	14 calendar days	MCP
Notification of Extension	<ul style="list-style-type: none"> Reasonable efforts to provide prompt oral notice Written notice within 2 calendar days. 	MCP
Effectuation of Overturned Decisions	72 hours	MCP
Internal Fair Hearings	An equitable process to manage unsponsored beneficiary grievances and/or an appeal of a provider level grievance.	
Filing	120 days	Beneficiaries or authorized representative.
Acknowledgement	5 calendar days	Designated Investigator
Standard Resolution	30 calendar days	Designated Investigator
Expedited Resolution	72 hours	Designated Investigator
Extension	14 calendar days	Designated Investigator
Notification of Extension	<ul style="list-style-type: none"> Reasonable efforts to provide prompt oral notice Written notice within 2 calendar days. 	Designated Investigator
State Hearings	In response to Notice of Appeal Resolution.	
Filing	120 days from NAR	Beneficiary or authorized representative
Standard Resolution	90 calendar days	State Hearings Division
Expedited Resolution	3 working days	State Hearings Division
Effectuation of Overturned Decisions	72 hours	State Hearings Division



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1. Attachments	<ol style="list-style-type: none">1. Notice of Grievance Resolution (NGR)2. Denial Notice (NOABD)3. Payment Denial Notice (NOABD)4. Delivery System Notice (NOABD)5. Modification Notice (NOABD)6. Termination Notice (NOABD)7. Timely Access (NOABD)8. Financial Liability (NOABD)9. NOABD "Your Rights" Attachment10. Notice of Appeal Resolution - Determination Upheld (NAR)11. NAR "Your Rights" Attachment12. Notice of Appeal Resolution - Determination Overturned (NAR)13. Beneficiary Non-Discrimination Notice14. Language Assistance Taglines
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